



Date \_\_\_\_\_

**MEDICAL INFORMATION**

This form should be completed for any person (under 19 years of age) in parish religious education, Catholic schools, and youth programs and should be completed on an annual basis at the beginning of the program.

Diocese \_\_\_\_\_ Parish \_\_\_\_\_ School \_\_\_\_\_

Participant's Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_

PLEASE PRINT OR TYPE

List below any physical condition the sponsors, doctors, nurses, or other medical personnel should be aware of:

Insect stings: \_\_\_\_\_

Fainting spells: \_\_\_\_\_

Allergies: \_\_\_\_\_

Ear infections: \_\_\_\_\_

Asthma: \_\_\_\_\_

Seizures: \_\_\_\_\_

Heart condition: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Headaches: \_\_\_\_\_

OTHER: \_\_\_\_\_

Date of most recent Tetanus Shot: \_\_\_\_\_

MEDICATIONS

Allergic reactions to any drugs (be specific): \_\_\_\_\_

Prescribed medication now being taken:

Type: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often: \_\_\_\_\_

Type: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often: \_\_\_\_\_

Type: \_\_\_\_\_ Dosage: \_\_\_\_\_ How often: \_\_\_\_\_

Activities individual should not participate in: \_\_\_\_\_



Date \_\_\_\_\_

**MEDICAL PERMISSION FORM**

This form is to be used for any parish, Catholic school, or diocesan field trips.

Diocese \_\_\_\_\_ Parish \_\_\_\_\_ School \_\_\_\_\_

Participant's Name \_\_\_\_\_

Destination \_\_\_\_\_

**TO WHOM IT MAY CONCERN:**

I/We understand that first aid will be available on the above mentioned trip. I/We further understand that should an accident, injury, or illness occur, medical and/or hospital care will be obtained. I/We realize the sponsors will make a reasonable effort to notify me/us in case of accident, injury, or illness; however, should they be unable to contact me/us, they have my permission to pursue a course of medical action which is in the best interest of the child.

I/We grant permission to the administration of first aid care to (Name) \_\_\_\_\_ by the people in charge of the \_\_\_\_\_ and those transporting my child to and from the \_\_\_\_\_ as their judgment deems advisable and to make the necessary referrals to qualified physicians or health care providers for treatment of illness or accidents. I/We understand that a reasonable effort will be made to promptly notify me in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of medical emergency, in the event I/we cannot be reached, I/we hereby give permission to the physician or health care provider selected by the adult staff to hospitalize, secure proper treatment for, and order whatever injection, anesthesia, or surgery said physician or health care provider deems necessary for the child.

A doctor, clinic, hospital, or health care provider may proceed with any medical or surgical treatment that such sponsor may authorize.

I further understand that I will be responsible for all medical, surgical, and transportation costs which may be incurred.

**INSURANCE INFORMATION:**

Insurance Company \*\* \_\_\_\_\_ Policy No. \_\_\_\_\_

Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Employer's phone # \_\_\_\_\_

\*\* If Blue Cross/Blue Shield Insurance please state if it is Blue Choice, Blue Select, etc.

(over)

\_\_\_\_\_  
(Father)

\_\_\_\_\_  
(Mother)

\_\_\_\_\_  
(Father)

\_\_\_\_\_  
(Mother)

Home telephone \_\_\_\_\_

Home telephone \_\_\_\_\_

Work telephone \_\_\_\_\_

Work telephone \_\_\_\_\_

If unable to contact either parent above, I grant permission to contact:

\_\_\_\_\_  
(Friend or Relative)

\_\_\_\_\_  
(Home or Work Telephone No.)

\_\_\_\_\_  
(Family Physician)

\_\_\_\_\_  
(Physician's Telephone No.)

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Parent/Legal Guardian Signature